TRANSACTIONS

OF THE

NEW YORK SURGICAL SOCIETY.

Stated Meeting, May 11, 1904.

The President, HOWARD LILIENTHAL, M.D., in the Chair.

MULTIPLE RESECTION OF INTESTINES IN CHILD SIX AND ONE-HALF YEARS OLD; POSTOPERATIVE OBSTRUCTION, WITH A THIRD ANASTOMOSIS; RECOVERY.

DR. JOHN F. ERDMANN presented a boy, six and one-half years old, who was admitted to Gouverneur Hospital on February 30, last, about 9 P.M. The history obtained was that some time between six and eight o'clock that evening he was run over by a wagon, the wheel or wheels passing from the anterior superior iliac spine of the left side upward and obliquely across the abdomen. A contusion about three inches long by an inch and one-half wide was seen in the vicinity of the left anterior superior iliac spine.

At 4 P.M. on the following day, when Dr. Erdmann first saw the patient, his temperature was 101.2° F.; pulse, 128. The abdomen was rigid and distended; there was pain on palpation. The patient had vomited; his bowels had not moved.

Through a median incision, a tear two inches long was found in the left peritoneal layer of the mesosigmoid. Further search revealed a mass of intestine, fully ten inches long, from which the mesentery was torn off, leaving a triangular gap with a base of about four and a half inches. The mid-portion of this section

contained a gangrenous area about one by two inches in size. A second section of the intestine, in close proximity, was found with a triangle of its mesentery ecchymotic and gangrenous. The base of this was fully two and a half to three inches long. The intestine supplied by the vessels of this portion of mesentery, about five and a half to six inches long, was gangrenous in several small areas, and at each end of the destroyed mesentery the intestinal loop had a peculiar, cordlike constriction. These two sections of intestine were excised and anastomosed with Murphy buttons. The abdomen was then closed without drainage, the entire operation taking forty minutes.

The boy's reaction to the operation was favorable. The first button was passed on the ninth and the second on the twentieth day. About the fifteenth day, the patient's abdomen began to swell and his countenance became anxious. There was total obstruction for twenty-four hours, when he again began to improve, and continued to do so until the 28th of March, when some of his family smuggled fruit and cake to him, of which he ate his fill, and which was followed by profound obstruction, tympany, and vomiting. The abdomen became rigid and painful; pulse, 140.

On March 30 the abdomen was again opened, and it was found that a complete separation had occurred between the ends of the formerly apposed and anastomosed sections. A pouch or walled-off pocket of about two inches long and fully two and a half inches in diameter was present, and by reason of overdistention this ruptured and permitted of sufficient leakage of intestinal contents to create the peritoneal manifestations. Owing to adhesions, it was impossible to bring these separated ends into the abdominal wound. They were thereupon anastomosed laterally by dropping one-half the button into each end, then taking a purse-string suture about each end fully three-eighths of an inch away from the free edge, and inverting the open end. As the sutures were drawn tight, the button halves were forced together by nicking the gut over the stem of the female half, and then forcing the male stem, covered by the intestinal wall, into it. The cavity was wiped out, a small drain placed in the vicinity of the anastomosis, and the wound sutured. The patient began to improve immediately, and had entirely recovered by May 1. The third button was passed ten days after its insertion.

STONE IN THE PELVIC URETER (FEMALE).

Dr. George E. Brewer presented a woman, forty-three years old, who was admitted to Roosevelt Hospital in the autumn of 1903. Fourteen years before she first experienced an attack of pain in the lower left abdomen; this attack lasted six days. Five years later she had a similar attack lasting twelve hours. This time the pain radiated to the groin and thigh, and there was a sense of numbness in the external genitals on the same side. Since that time she had had about a dozen similar attacks, with more or less constant discomfort in the flank and groin. In one of these attacks there was moderate hæmaturia. Three years ago she underwent an operation on the left ovary, which was followed by a period of relief for several months. The pain, however, recurred, and during the past two years it had been at times severe and compelled her to give up her work.

When the patient was admitted to the hospital she had an extensive ventral hernia at the site of the previous operation. There was moderate tenderness over the left kidney at a point two inches below and to the left of the umbilicus, in the neighborhood of the external abdominal ring, and, by vaginal examination, in the left half of the roof of the pelvis. These points of tenderness varied somewhat on different occasions, and at times none but the kidney tenderness could be elicited. The urine was cloudy, containing a faint trace of albumen and considerable pus. While in the hospital she had an acute attack of colic, the pain radiating to the groin and thigh, but without hæmaturia or evidences of hydronephrosis. An X-ray examination of the kidney was negative. The attack of colic was so characteristic, however, that an exploratory operation was advised.

Under ether anæsthesia, a generous oblique incision was made in the flank, exposing the kidney and upper part of the ureter. The kidney was incised, the finger passed into its pelvis and every calyx explored, with negative result. A flexible, metallic ureteral sound was passed into the ureter and could be introduced to the wall of the bladder; beyond that point it could not be pushed. There was no feeling of a foreign body touching the sound, its failure to pass into the bladder being apparently due to stenosis of the ureteral orifice rather than to obstruction by a calculus. To verify this, however, the incision was extended

to the inguinal region, and the ureter followed down with the finger to its junction with the bladder. As no stone could be felt, and as the injection of a solution of methylene blue into the pelvis of the kidney immediately appeared in the bladder urine, further search was abandoned. The wound was closed by layer sutures, a small cigarette drain being left, extending to the kidney incision.

The wound healed kindly, and several weeks later the patient submitted to an operation for the cure of the ventral hernia. While she was still in bed from the latter operation, another attack of colic occurred similar to those she had experienced before. After her recovery from the last operation, another X-ray picture was taken obliquely through the pelvis, which showed the presence of a calculus in the lower end of the ureter. The patient refused further operative treatment and was discharged from the hospital. Three or four months later she experienced an attack of acute, left-sided pain, accompanied by chills, fever, and sweats. During the attack, the region of the left kidney was exquisitely tender; the kidney was apparently enlarged from distention of its pelvis. This attack subsided in about one week. Two or three weeks later she was readmitted to the Roosevelt Hospital.

Under ether anæsthesia, the urethra was dilated until it admitted the forefinger. With this the region of the left ureteral opening was palpated, and a small, oval calculus distinctly felt beneath the mucous membrane. The bladder was then distended with ten ounces of sterile salt solution. The bladder was opened above the pubes and its walls retracted with three large abdominal retractors. A bent probe passed through the left ureteral orifice touched the stone. The orifice was then slit up for a distance of a quarter of an inch, the stone readily seized with the forceps, and withdrawn. After thorough irrigation, the bladder was closed tightly with three layers of chromicized catgut, the other structures approximated, and the cutaneous wound partly closed with silk. A small gauze drain was left, extending to the cavity of Retzius. The patient was catheterized every two hours for the first three or four days. The wound healed kindly; there was no leakage; the patient had since been entirely free from pain.

STONE IN THE PELVIC URETER (MALE).

DR. BREWER presented a man, thirty-four years old, who was admitted to the Roosevelt Hospital in March, 1904. When he was eight years old, he experienced an attack of right-sided colic, the pain radiating from the flank to the groin, glans penis, and testis. Since that time he has had many similar attacks. At thirteen years of age he had a very severe attack, which lasted five days and was accompanied by the passage of red urine. Eleven years later he had another severe attack which lasted six days. In none of these attacks was there any apparent swelling in the region of the kidney. Three years ago an X-ray picture taken of the kidney region was negative.

Up to one year ago the patient was under the care of Dr. George K. Swinburne, of this city, who informed Dr. Brewer that the urine had always been clear and free from any evidence of renal or bladder infection. Shortly after this the patient visited a dispensary, where a sound was introduced for purposes of exploration. This was immediately followed by an acute infection of the bladder, and since that time the urine had never been free from pus. Six months ago the right kidney was explored at the City Hospital. No stone was found, but, as the kidney was somewhat movable, nephrorrhaphy was done. No relief followed this procedure, and during the past five months the patient had suffered more or less constant pain in the right inguinal region, chiefly located at a point near the external abdominal ring. Three days ago he experienced another severe attack, which was so acute in character that he was unable to sleep, and for two days he rolled about on the bed and floor, screaming and vomiting. The urine was albuminous and turbid from pus. There was slight tenderness over the kidney and ureter, more particularly over its lower portion. An X-ray examination revealed the presence of a stone in the pelvic ureter, near the spine of the ischium.

Under ether anæsthesia, a curved incision was made about two inches about Poupart's ligament, and the muscular layer divided until the peritoneum was reached. This was retracted inward and stripped from the side wall of the pelvis, freely exposing the iliac vessels and ureter. The ureter was easily followed into the pelvic cavity, and the stone was found about one inch below the brim of the pelvis. Above this point the ureter was

dilated to the size of the forefinger and considerably thickened. The stone was easily pushed upward to a more healthy portion of the ureter and extracted through a small, longitudinal incision. This incision was then tightly closed with a single row of fine, chromicized catgut sutures. Over this was placed a mass of subperitoneal fat, which was also sutured to the ureteral wall. After this the parts were allowed to fall into place and the wound united by layer suture. A small cigarette drain was left in the lower angle of the wound, extending to the subperitoneal space.

The patient's recovery was uneventful. There was no leakage. He was discharged on the twenty-fifth day after operation.

DR. LILIENTHAL said that he had a case under his observation at present in which the symptoms pointed to the presence of a stone in the pelvic ureter. A few days ago, after an injection of indigo-carmine in the gluteal regions, both ureters were catheterized. The urine drawn from the left side, where the symptoms were practically *nil*, escaped freely and contained plenty of coloring matter. On the right side, where the kidney was rather large and movable, very little urine escaped, and this contained scarcely any coloring matter. This was probably due to the fact that the kidney on that side was not secreting. One of the symptoms that had led to the suspicion of stone was hæmaturia. X-ray pictures of both kidneys failed to show the presence of stone.

DR. BREWER said that about a year ago he saw a case in which the X-ray disclosed the presence of a ureteral calculus. In spite of severe and repeated attacks of colic, the patient refused operation. One night, during such an attack, he drank two quarts of Poland water within an hour, and after another hour of excruciating pain the calculus was spontaneously expelled.

About eight weeks ago, Dr. Brewer said, he was called to see a young woman who was supposed to have appendicitis. She was having a good deal of pain, which was located exactly over the external abdominal ring. He decided that the case was not appendicitis, and advised against operation. Six weeks later he was again called to see her. He was still convinced that the case was not one of appendicitis, but, as the pain had lasted about two months, an exploratory operation was deemed justifiable. The patient was sent to the hospital and an X-ray picture taken, which revealed a stone in the ureter, and thus cleared up the diagnosis.

ADENOMA OF AN ACCESSORY THYROID, CAUSING MARKED TRACHEAL STENOSIS.

DR. BREWER presented a man, fifty-two years old, a physician, who first came under his observation in the latter part of March, 1904.

Some three years ago, on exertion, he first noticed slight difficulty in breathing. He attributed this to lack of exercise and progressively increasing body weight. Some months later it was noticed that there occurred occasional attacks of rather pronounced dyspnœa, always following some unusual exertion. Believing that the trouble was asthmatic in character, his treatment consisted of the usual remedies for this condition. During the past six months the difficulty in breathing had greatly increased, the dyspnœa becoming almost continuous. At certain times it was intense, and would be accompanied by cyanosis. This so interfered with his work that he at last consulted Dr. Francis J. Quinlan, of this city, who on examination with the laryngoscope readily detected a very decided encroachment upon the caliber of the trachea by an oval mass apparently springing from the right half of the tracheal wall. This tumor was smooth, oval, and covered, apparently, with healthy mucous membrane. It left a semilunar tracheal aperture about a quarter of an inch in diameter. The patient was also seen in consultation by Dr. Holbrook Curtis, who verified the diagnosis and referred him to Dr. Brewer for treatment.

In addition to the above findngs, Dr. Brewer noticed a very slight bulging at the root of the neck, to the right and just above the sternoclavicular articulation. On deep palpation, a hard, oval mass was felt extending into the mediastinum. Moderate pressure on this mass caused an immediate increase in the dyspnœa, and a greater degree of pressure produced absolute tracheal obstruction. From these findings, the diagnosis was made of an extratracheal tumor, producing a marked indentation of the right wall of the trachea.

As a course of potassium iodide had already been tried without any improvement, an immediate operation was advised.

During the following four or five days, while the patient was arranging his affairs preparatory to entering the hospital, the dyspnœa was markedly increased. He was unable to lie down, and on the night before entering the hospital his symptoms were

so urgent that a brother physician passed the night in his house administering oxygen and stimulants freely. On the following afternoon he was again seen at the hospital by Dr. Brewer, in consultation with Drs. Quinlan and Curtis. The symptoms were so urgent at this time that it was decided to operate immediately, as it was feared he could not survive until the following morning.

In view of the alarming dyspnœa and the difficulties of the operation, it was decided to intrust the anæsthetic to Dr. Thomas L. Bennett, who promptly responded and administered chloroform. The patient at first took the anæsthetic kindly, but as soon as the position of the head was changed to allow the performance of a preliminary tracheotomy, the dyspnœa became extreme, with grave cyanosis.

An incision was made in the median line from the cricoid to the suprasternal notch, and thence continued downward towards the right in a curved direction for about three inches. The tissues overlying the trachea were rapidly divided and retracted, until the isthmus of the thyroid was exposed. This occupied practically the entire space between the cricoid and the sternum, and was exceedingly voluminous and vascular.

Considerable delay was caused by the application of a number of mass ligatures, so that the thyroid tissues could be divided to expose the trachea. While this was in progress the patient ceased to breathe and the skin became livid. As the cut surface of the thyroid was bleeding profusely, it seemed unwise to make an attempt to open the trachea, which was pushed well to the left by a large, encapsulated tumor which lay beneath the thyroid gland, partly within and partly above the mediastinum. About a minute and a half were consumed in arresting the hæmorrhage, during which time the respiration was completely arrested. As soon as the hæmorrhage was controlled, an incision was made into the trachea, and an attempt made to introduce a tube. Owing to the narrowness of the lumen, only the smallest-sized infant tube could be introduced. Respiration was at once re-established, and the patient's color improved. The thyroid and other tissues were gradually dissected away from the tumor, which was found to be completely encapsulated, and to lie closely adherent to the trachea, the œsophagus, the recurrent laryngeal nerve, the jugular and innominate veins, and the innominate artery. About one hour was consumed in dissecting the tumor free from these structures,

after which the wound was partly closed; a large drain was left in the middle third, with the view of keeping the wound open and exposing the tracheal wall for subsequent X-ray treatment in case a histological examination revealed any signs of malignancy.

The patient's recovery was prompt, and, aside from a short period of iodoform poisoning, it was uneventful. Laryngoscopic examination showed a paralysis of the right vocal cord, but a great increase in the lumen of the trachea. The vocal paralysis was undoubtedly due to division of the recurrent laryngeal nerve. On examination, the tumor proved to be an adenoma, probably of an accessory thyroid, and it showed in places slight changes suggesting carcinomatous degeneration.

DR. F. KAMMERER said that surgeons who had much experience with thyroid tumors could well appreciate the difficulties of an operation like the one described by Dr. Brewer, especially when hæmorrhage and dyspnœa were present at the same time, and the question arose which of the two to attend to first. The situation thus created was one of the most trying surgeons could meet with. Years ago, when the speaker saw cases more frequently, it was considered a very dangerous procedure to do a tracheotomy in connection with extirpation of the thyroid gland. The former should only be done when all other attempts to relieve dyspnœa had been exhausted. The large wound cavity was liable to be infected after opening the trachea, and therein lay the danger.

Dr. Kammerer said that as long as a malignant tumor of the thyroid did not perforate its capsule, the prognosis was relatively good. He recalled one such case, a large, encapsulated malignant tumor, in which the patient lived for a period of twelve years. When perforation and carcinomatous infiltration of surrounding tissues had occurred, the outlook was very unsatisfactory.

DR. FRANCIS J. QUINLAN (by invitation) said that when the patient shown by Dr. Brewer first came under his observation, which was several weeks prior to the operation, he presented all the symptoms of one who was suffering from stenosis of the larynx or trachea. The laryngoscope revealed the cause of the dyspnœa. The trachea had the appearance of a funnel struck by a hammer. Although there was no reason to suspect syphilis, the patient was given a thorough course of specific treatment, without resulting benefit. Macroscopically, the tumor removed by Dr. Brewer looked like an enormous sarcoma.

DR. BREWER said that while the supposition was that this was an adenoma of an accessory thyroid, it was evident that the thyroid was separate from this distinctly encapsulated tumor. It was easily peeled off and separated. Its lower part was fibrous in character. The speaker said his impression was that it was one of those thyroid masses which grew in the wall of the gland, and yet were distinct from the thyroid itself.

CALCULI IN THE COMMON DUCT; CHRONIC CHOLANGEITIS; CHOLECYSTECTOMY AND CHOLEDOCHOTOMY.

DR. CHARLES H. PECK presented a man, aged fifty years, who was referred to him, March 22, 1904, by Dr. L. O. Monory. The man had been ill for about three years with pains in the upper abdomen, chills, fever, sweating, slight jaundice, and loss of flesh and strength. For a long time he had been under treatment in Philadelphia, where he had consulted a number of physicians, but obtained only temporary relief. He came to New York in November, 1903, and had been more or less constantly under treatment. While not confined to bed, he was too ill to attend to his work. The chills, fever, and attacks of pain occurred frequently, but without regularity; usually at intervals of from one to three days. The chills were often severe, lasting from twenty to thirty minutes. The pain was variable in character and duration, often lasting several hours. Icterus slight and variable.

While the patient was in Dr. Peck's office he was taken with a severe chill, which lasted about twenty minutes. His temperature immediately afterwards, taken in the mouth, was 102° F.; pulse, 112. On examination, there was an area of increased resistance in the region of the gall-bladder, but the mass could not be distinctly outlined. There was moderate tenderness and rigidity; otherwise, abdominal palpation was negative. Slight icterus. Leucocyte count, 17,000.

The patient was admitted to the French Hospital on March 29, 1904. He had had no chills during the preceding week, and the pain and tenderness have subsided considerably. Leucocyte count, 11,000. Operation, two days later, under ether anæsthesia. The region of the gall-bladder was exposed through a five-inch incision, vertical through the right rectus, then oblique towards xiphoid. The gall-bladder was buried in dense adhesions, small and thick-walled, firmly attached to the transverse colon. Chole-

cystectomy was done by the Lilienthal method, with a traction suture of chromic gut through the cystic duct, and a clamp above it at the base of the gall-bladder. A perforation on the under surface of the gall-bladder was exposed on separating it from the transverse colon, and a small quantity of bile escaped, the dense adhesions having prevented previous leakage. The viscus measured less than two inches in length; its walls were greatly thickened; its cavity much contracted. A small amount of thin pus was found in a closed pocket at the fundus.

The stump of the cystic duct was now drawn up by the traction suture, and a greatly dilated common duct exposed, in which a movable stone could be felt. With scissors, the stump of the cystic, common, and hepatic ducts were freely slit open; both the hepatic and common ducts were much dilated, readily admitting the forefinger. A large stone was felt high in the hepatic duct and removed with forceps; another was removed from the lower end of the common duct, where it had acted as a ball-valve. A probe was passed into the duodenum, and no other calculi were found. A small drainage tube was passed well into the hepatic duct and fastened in place by two fine, chromic gut sutures, placed laterally, as suggested by Mayo. A single chromic gut stitch was then taken in the common duct below the tube, and, after cleansing, three cigarette drains were placed in Morrison's space down to the duct. The abdominal wall, excepting at the point of drainage, was closed.

The patient reacted well from the operation, and his bowels moved in response to an enema at the end of forty-eight hours. Bile drained freely through the tube in the hepatic duct until the third day, when the tube was removed. Subsequent to this, bile escaped from the wound in constantly diminishing amount until the twenty-second day.

There was no recurrence of pain, chills, nor fever after the operation, and convalescence was uneventful, with the exception of a slight separation of the upper end of the wound, which was caused by the patient's getting out of bed about the sixth or seventh day. This caused some delay in the closure of the abdominal wound. The patient left the hospital on May 3 practically well.

DR. LILIENTHAL thought the method followed by Dr. Peck was superior to that suggested by Mayo in a recent issue of the

New York Medical Record. In cholecystectomy by the latter method, the beginning was made in the cystic duct, and ligation was practised with the idea that there would be less hæmorrhage. The speaker said he did not think the hæmorrhage was apt to be severe; certainly not until the cystic duct was reached. What bleeding there was came from the liver. The disadvantage of the method was that one then had the cystic duct sealed, and if it became necessary to proceed with work on the common duct, another operation, choledochotomy, would have to be done.

Referring to the small size of the gall-bladder in Dr. Peck's case, Dr. Lilienthal said that the small gall-bladders were usually more difficult to take out than large ones.

DR. PECK, in closing, said that this was the first time he had attempted a cholecystectomy by this particular method. The hæmorrhage was easily controlled. The chief difficulty was in separating the adhesions from the transverse colon and liver. The hepatic and common ducts were so large that they could be easily followed, and with the finger the stone could be palpated. The readiness with which the widely opened hepatic and common ducts closed upon suture was particularly gratifying. The closure was continuous, and complete in about three weeks, although they had been laid widely open for a distance of over two inches.

NEPHRECTOMY FOR SARCOMA.

DR. CHARLES N. DOWD presented a girl, six years old, who was admitted to St. Mary's Hospital on March 28, 1904. Her family and previous personal history was unimportant, and the child was in good health until six months before her admission, when she began to have pain in the left hypogastrium and left lumbar region. She frequently felt nauseated. She first noticed a swelling in the left hypogastrium two months before admission. This had grown rapidly. She had lost much in weight and strength. Her urine had occasionally been dark-colored of late.

When the patient came to the hospital she was pale and emaciated. The heart and lungs were normal. The abdomen was greatly distended and the superficial veins much dilated. A tense, elastic, smooth tumor could be felt within the abdomen, extending from the diaphragm into the left part of the pelvis, pushing back into the lumbar region and across the median line in front for two or three inches. Its general outline was globular; it was

very slightly movable. The urine was of a specific gravity of 1028; acid; it contained no albumen, blood, casts, nor sugar. The leucocyte count was 13,000.

March 30, an oblique incision was made, beginning at the twelfth rib at the margin of the quadratus lumborum above the anterior superior iliac spine, and extending across to the median line below the umbilicus. The peritoneum was incised for about four inches. The tumor was only slightly adherent to the surrounding tissues, and was enucleated with little difficulty and very slight hæmorrhage. The ureter and renal vessels were ligated separately. The peritoneal wound was closed with catgut, the fascia with chromicized gut, and the skin with silkworm gut, with a small silkworm-gut drain. Convalescence was prompt and uneventful. There was a free secretion of urine, of good quality, from the start.

Pathologically, the tumor proved to be a sarcoma of the perithelial type, originating within the kidney capsule, probably from the outer coating of the blood-vessels. It seemed not to be of adrenal origin.

The pathological report by Dr. Frank S. Mathews was as follows: "The tumor lies beneath the kidney capsule, and between it and the kidney parenchyma. On section, the tumor is found to consist of cells, spindle or polyhedral, sometimes arranged in rows, with a small amount of stroma between them. The masses of tumor cells are arranged around a central blood-vessel. These vessels often have a wide lumen, and do not show the usual number of coats, but the tumor mass of cells seems to take the place of adventitia.

"The striking features of the tumor are its relation to the blood-vessels, and the rows of cells extending radially from the central blood-vessels. Sections at the junction of the tumor and renal parenchyma show the tubules and tufts compressed but not infiltrated with tumor tissue. In other places, the kidney tissue remains practically normal. The diagnosis is perithelioma, or perithelial sarcoma."

Dr. Dowd said the case illustrated the ease with which these sarcomata could sometimes be removed, even after attaining a large size. As bearing upon the prognosis and the ordinary operative mortality, the statistics collected by Dr. Waller, of Baltimore (ANNALS OF SURGERY, Vol. xxvi), were of interest. A careful

study of the recorded cases and a review of the histories of seventy-four operative cases showed that the operative mortality was 36.48 per cent. and the mortality within three years between 73 and 93 per cent. The percentage of cures followed beyond the three-year limit was 5.4 per cent. The life period was apparently increased 8.69 months by the operation.

DR. KAMMERER said he was surprised to hear that Dr. Dowd had experienced so little difficulty in developing such a very large tumor. In a similar case which the speaker reported about five weeks ago, signs of a recurrence had already become apparent. In that instance, great difficulty was experienced in raising the tumor above the crest of the ileum with the patient in the lateral position. Out of six cases that had come under his observation, the speaker said he had succeeded in extirpating the tumor in three. The three in which he had been unsuccessful were his earlier cases, and he had perhaps been too timid in his attempts, on account of the size of the growths.

DR. LILIENTHAL asked Dr. Dowd whether he employed the Trendelenburg posture in operating on his case? In two cases that had come under his observation, he had been enabled to extirpate the growths without opening the peritoneum at all. In one of these the tumor was almost as large as the specimen shown by Dr. Dowd; in the other it was smaller. The Trendelenburg posture was employed in both instances, and seemed to facilitate the manipulations very much. The speaker recalled two cases of enormous sarcoma of the kidney that had been shown some years ago by Dr. Abbe, who emphasized the importance of this position in facilitating the work.

DR. KAMMERER said he thought the ideal posture in these operations was the lateral position. Personally, he would attack all these tumors from the retroperitoneum, opening the peritoneum, however, in order to assure himself as to the position of the ascending or descending colon. The colon was at times not recognizable to the touch, but when seen it could easily be stripped off to the inside of the growth.

DR. DOWD, in closing, said that he had considered the use of the Trendelenburg position in this case, but thought that it would not have been an advantage. No great difficulty was experienced in removing the growth. The peritoneum laid over it like a fold, and would have had to be incised, no matter what the posture was.

PLASTIC OPERATION FOR THE RESTORATION OF THE LOWER LIP.

DR. F. KAMMERER presented an old man, whose entire lower lip had been involved in an epitheliomatous growth. In order to remedy the defect left by its removal, a quadrangular flap was removed from the cheek, carried down, and sutured to the remnant of the lower lip. The cosmetic effect of the operation was excellent. Dr. Kammerer said he thought this method was preferable to that of carrying a flap up from the neck, as the latter did not possess the advantage of an internal mucous surface.

REMARKS ON POSTOPERATIVE INTESTINAL OBSTRUCTION, WITH A REPORT OF THREE CASES.

DR. CHARLES H. PECK read a paper with the above title, for which see page 510.

DR. JOHN F. ERDMANN said he had seen several cases of postoperative intestinal obstruction. Three years ago he was called upon to relieve this condition in a boy who had been operated on in Brooklyn eight months previously for a suppurative appendicitis. When Dr. Erdmann saw him, he was suffering from profound intestinal obstruction. This was found to be due to an adhesive band. The cause of the obstruction was relieved, but the patient died from shock.

Four years ago he operated on a boy at St. Mark's Hospital. The patient had been running a septic temperature for several weeks, and had a large tumor in the right iliac region. This proved to be an abscess. This was evacuated, leaving an immense cavity, which required prolonged packing. It finally healed, and the patient left the hospital, refusing to submit to any further operative interference for the purpose of removing the appendix, from which the abscess had probably originated. Several months later he had an attack of intestinal obstruction, and died without operation.

The question of postoperative intestinal obstruction, Dr. Erdmann said, seemed to him to be largely one of prophylaxis. A movement of the bowels should be insisted on within twenty-four hours after the operation, and during each succeeding twenty-four hours. No morphine should be given; if any opiate is needed for the pain, codeia would usually be found satisfactory. Personally,

the speaker said, he had never had a case of postoperative intestinal obstruction, excepting in the abscess case reported above.

DR. BREWER said he thought these cases were comparatively common. He had certainly seen six or seven cases of postoperative intestinal obstruction, three within the past year. One of these followed general peritonitis after an operation on the gall-bladder; one resulted from an abscess of the appendix, and the third occurred in a woman who had had eleven laparotomies performed for various reasons, most of them for intestinal obstruction. In that case, Dr. Brewer's laparotomy was the sixth time the patient's abdomen had been opened for intestinal obstruction. The intestines were everywhere matted together, and there were a number of distinct angulations. She recovered from that operation, but a recurrence of the condition was looked for.

DR. LILIENTHAL was also of the opinion that intestinal obstruction following intra-abdominal operations was unfortunately very common. He recalled one case where he had operated for a ruptured liver abscess. The man had general peritonitis, from which he recovered. A year later he had intestinal obstruction, for which he was operated on too late and died. In two other cases coming under his observation, the intestinal obstruction followed operations for acute appendicitis.

Dr. Lilienthal said he did not think it was always possible to prevent the formation of adhesions. Some persons seemed to have an idiosyncrasy in that direction, and became subject to permanent adhesions more readily than others. Women seemed to be more subject to them than men. He had seen cases of so-called clean appendicectomy followed by adhesions. The speaker said he thought Dr. Peck had done a valuable service in emphasizing the fact that all cases of laparotomy should be watched for several weeks subsequent to the operation, particularly in respect to diet and the action of the bowels. These factors were too often neglected.

DR. DOWD mentioned a case of intestinal obstruction in which he had assisted Dr. Henry C. Coe where the condition was the result of injections made by a quack for the cure of hernia. An enormous number of adhesions were found, producing tight occlusion of the intestine. The injections in that case must have been made into the peritoneal cavity.

DR. PECK, in closing, said he particularly wished to empha-

size the importance of the after-treatment of laparotomy cases. If these patients were safely tided over the first six or eight weeks, the great majority of adhesions would have become absorbed by that time, and the danger of intestinal obstruction would be comparatively slight. As Dr. Lilienthal had suggested, some persons may be predisposed to the formation of permanent adhesions; but in the great majority of cases the obstruction occurred within the first two weeks, and many of them could probably have been prevented by proper attention to diet and the condition of the bowels.